DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Second Sub

PRINTED: 10/05/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185246	A. BUILDING _____ B. WING _____	C 08/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKCASTLE HEALTH & REHABILITATION CENTER	371 WEST MAIN STREET BRODHEAD, KY 40409

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F 000	INITIAL COMMENTS A standard health survey was conducted on August 24-26, 2010. Deficient practice was identified with the highest scope and severity at "E" level. An abbreviated standard survey (KY15123) was also conducted at this time. The allegation was unsubstantiated.	F 000	*Rockcastle Health and Rehabilitation, a Signature Healthcare Facility does not believe and does not admit that any deficiencies existed, either before, during or after the survey. The Facility reserves all rights to contest the survey finding through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all right to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should consider as a waiver of any potentially applicable peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality care to residents.*	
F 157 SS=E	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	F157 1. Resident #2 was reassessed and the intake record reviewed on 8-31-2010. The resident had a routine appointment University of Kentucky Medical Center on 8-31-2010. A summary was completed of the resident exceeding the fluid restrictions from 9-1-2010 thru 9-9-2010, the	10/10/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: David L Dickerson, NHA — TITLE — (X6) DATE: 10/6/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to notify the physicians of four (4) of twenty (20) sampled residents (residents #2, #5, #7, and #13) of a need to alter treatment. Resident #2 exceeded the physician-ordered fluid restriction in July and August 2010. There was no evidence resident #2's physician was notified. In addition, residents #5, #7, and #13 developed skin redness/rashes/excoriation. There was no evidence the residents' physicians were notified. Further, there was no evidence resident #7's Responsible Party (RP) was notified that the resident had reddened/excoriated skin. The findings include: 1. A review of resident #2's medical record revealed the resident was admitted to the facility on April 26, 2010, with diagnoses that included End Stage Cirrhosis of the Liver. A review of the physician's orders dated July 10, 2010, revealed an order to decrease the resident's fluid restriction to 1000 cubic centimeters (cc) per day. A review of resident #2's monthly intake record for July 2010 revealed from July 10-31, 2010, resident #2 exceeded the 1000-cc fluid restriction on 14 of 22 days. For five days in July 2010 the facility had not calculated the resident's 24-hour fluid consumption. A review of the monthly intake record for August 1-24, 2010, revealed resident	F 157	physician/responsible party was notified on 9-10-2010. Resident #5 was reassessed and the physician/responsible party were notified on 8-25-2010 regarding the skin redness and excoriated area under the left breast. Resident #13 was reassessed and the physician/responsible party were notified on 8-25-2010 regarding the rash under the right breast. Resident #7 was reassessed and the physician/responsible party were notified on 8-24-2010 regarding the reddened areas on the buttocks, scrotum, and inner thighs. 2. All residents with orders for fluid restrictions have had their intake records reviewed and the physician notification/responsible party has been done as appropriate. A skin sweep of all residents was completed on 9-15-2010 and notification to the physician/responsible party has been done as appropriate. 3. DON, Staff Development Coordinator (SDC) or designee will have re-educated all Licensed staff by 9/30/2010 on physician and responsible party notification when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental,	

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F 157	Continued From page 2 #2's fluid intake exceeded 1000 cc of fluid for eleven days and the resident's 24-hour fluid intake was not calculated for seven days. On August 25, 2010, from 10:10 p.m. to 10:45 p.m., an interview with three nurses who worked the 7 p.m. to 7 a.m. shift revealed night shift nurses or nursing assistants were required to calculate the residents' 24-hour fluid intake records during the night shift. The nurses stated if a resident did not meet the resident's fluid requirement, or if the resident exceeded their fluid requirements for three days, the resident's physician was required to be notified. However, the nurses were not consistent regarding who was responsible to calculate resident fluid consumption records and who was responsible to notify the resident's physician. One nurse stated he/she reported the information on to the next shift and "they handle it." An interview with the Unit Manager on August 26, 2010, at 5:15 p.m., confirmed resident #2's physician was required to be notified if the resident exceeded the fluid restriction for three days. The Unit Manager stated the night shift nursing assistants were responsible for totaling the resident's fluid intake for the previous 24 hours and the night shift nurse was responsible for faxing a hydration alert form to the resident's physician when the resident did not meet their recommended fluid requirements or if a resident exceeded their fluid restriction. However, the Unit Manager had no documented evidence that resident #2's physician had been notified that the resident exceeded the fluid restriction. 2. Observation of resident #5's skin on August 25, 2010, at 2:50 p.m., revealed redness and	F 157	or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility. Emphasis was placed on notification of any change such as redness/rashes/excoriation/etc. of skin and exceeding fluid restrictions. This included a review of the skin and hydration policy. Nursing assistants were re-educated by DON/SDC/Designee on completing the C.N.A. Skin Care Alert sheet and on promptly reporting any changes in the resident's skin to the nurse. 4. Physician orders, 24 hour report, CNA Skin Care Alert sheets, and Weekly Skin Assessments will be reviewed by Nursing Administration (including but not limited to – the DNS, Unit Managers, MDS Coordinator, MDS Nurse, and the Treatment Nurse) during the clinical meetings in order to identify notification of the physician/responsible party and concerns will be addressed immediately. This information will also be presented to the QA meeting monthly by the DNS for three months. The QA committee will discuss the need for further education, root cause, interventions, action plans, and further follow-up as indicated. 5. Date of completion: 10-10-2010	

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F 157	Continued From page 3 excoriation under both the resident's breasts and an open skin area under the left breast that was approximately one inch long. Review of the state certified nursing assistant (SRNA) skin assessment sheets for July and August 2010 revealed documentation of redness under the resident's breasts on July 27, 2010. According to the documentation, the nurse was notified and cream was placed under the breast. A review of the August 2010 weekly skin assessments revealed on August 4, 2010, the resident had a slightly red area under the right breast. On August 18, 2010, the nurse documented resident #5 had a red area under the breast and a treatment was applied. Interview on August 25, 2010, at 2:50 p.m., with the Licensed Practical Nurse (LPN) performing the skin assessment and care for resident #5 revealed the LPN was unaware of the excoriation and redness under resident #5's breasts, and was unaware of any treatment needed to the breast area. Interview further revealed when new skin problems were observed a skin report was required to be completed, and the physician was required to be notified. Record review of nursing notes from May through August 2010 revealed no documentation of physician notification concerning the red areas under resident #5's breasts. 3. Observation on August 25, 2010, at 4:50 p.m., of resident #13 revealed the resident was sitting in a chair in the resident's room with blood noted on the front of the resident's shirt. Observation of the resident's skin underneath the right breast	F 157		

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F 157	Continued From page 4 revealed a raw, red rash and the area was actively bleeding. Resident #13 stated the right breast was "hurting so bad" the resident was "getting nauseated." In addition, resident #13 stated no treatment had been administered to the area. Review of resident #13's Weekly Skin Rounds revealed redness was noted under the resident's breasts on July 24, 2010; however, the physician was not notified until August 21, 2010. There was no documentation that the resident's physician was notified when the resident began having bloody drainage from the red areas under the resident's breasts. An interview conducted on August 25, 2010, at 5:05 p.m., with LPN #1 revealed the LPN was unaware of the bloody area under resident #13's right breast. 4. Observation of resident #7 on August 24, 2010, at 10:50 a.m., during the initial tour of the facility revealed staff was present assisting the resident with a bed bath. Observation of the resident's buttocks, scrotum, and inner thighs revealed the areas were bright red. The redness to the scrotum and inner thighs was not blanchable. Staff was observed to apply "Nutrashield" cream to the reddened areas. Further observation of resident #7's skin on August 24, 2010, at 5:25 p.m., with the staff nurse assigned to provide treatments/conduct skin assessments on the unit where resident #7 resided revealed the resident's bottom, scrotum, and inner thighs continued to be bright red. According to the nurse, the resident's left inner thigh appeared to have a "blister there at one	F 157		

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F 157	Continued From page 5 time." According to the nurse, resident #7 had a treatment ordered for the area but the nurse was unsure how long the reddened areas had been present. An interview with the nurse assigned to provide care to resident #7 on August 24, 2010, at 6:00 p.m., revealed the nurse was not aware the resident's skin was reddened prior to being told a few minutes before the interview. The nurse stated the resident had a rash that "comes and goes" and had orders for Nystatin cream to apply to the rash. An interview with the Kentucky Medication Aide (KMA) for resident #7 on August 25, 2010, at 3:30 p.m., revealed the KMA was not aware the resident had these reddened areas. According to an interview with the nurse aide assigned to resident #7 on August 24, 2010, at 5:45 p.m., the resident's skin was not reddened approximately two weeks prior; however, the resident did get red at times and it "really, really hurts." The nurse aide stated when the resident's skin got red, the nurse aide left the resident's brief open so the resident's skin could get air. On August 25, 2010, at 5:05 p.m. and 11:00 p.m., interviews with two other nurse aides (CNAs #1 and #2) who provide care for resident #7 revealed they were aware resident #7 had redness to the bottom and groin areas. CNA #1 stated resident #7 stated the areas to the scrotum and legs "hurt." CNA #1 stated he/she applied a protective barrier to the areas. CNA #2 stated resident #7's redness/rash looked better at times but never completely went away. The CNA stated he/she always notified the nurse of the redness/rash and	F 157		

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F 157	Continued From page 6 the nurse would ask how long the cream (protective cream) had been in use and would tell the CNAs to continue to utilize the cream or leave the areas open to air. A review of the "C.N.A. Skin Care Alert" documentation revealed resident #7's groin area was red/rash/irritated on July 6, 16, and 20, 2010, and on August 3, 13, and 17, 2010. A review of the weekly skin round forms revealed on July 13, 2010, staff documented resident #7's buttocks were "red blanchable." A review of resident #7's medical record revealed no evidence the resident's physician was notified that resident #7 had redness/excoriation to the resident's bottom, inner thighs, or groin area. An interview with resident #7's responsible party (RP) on August 26, 2010, at 2:48 p.m., revealed the RP was not aware the resident had reddened/excoriated skin areas. A review of the facility's Skin Management and Prevention Policy/Procedure that was not dated revealed if a new skin condition was identified the charge nurse was required to notify the resident's physician and the resident's family. The policy stated any new skin condition should also be documented on the appropriate form (Individual Skin Report and the Skin Ulcer Change of Condition Evaluation, if appropriate). An interview with the Unit Manager on August 26, 2010, at 5:15 p.m., revealed when a skin issue was identified staff should complete an Altered Skin Integrity form and an Individual Skin Report form. According to the Unit Manager, the forms contained specific areas to document that the resident's physician and responsible party were	F 157		

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F 157	Continued From page 7 notified. There was no evidence that these forms were completed for residents #5, #7, or #13. According to the Unit Manager, most of the facility staff was new and may not have known to complete the required documentation.	F 157	F281 1. Resident #2's fluid restriction order has been reviewed and has been forwarded to the Dietary department on 8-4-2010 and 8-26-2010.	10/10/10
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure the services provided met professional standards of quality for six (6) of twenty (20) residents. The facility failed to ensure physician's orders were carried out for residents #2, #3, #8, #13, and #16. In addition, there were errors in technique when medications were administered to residents #3 and #21. The findings include: 1. A review of resident #2's medical record revealed the resident was admitted to the facility on April 26, 2010, with diagnoses that included End Stage Cirrhosis of the Liver. A review of the physician's orders dated July 10, 2010, revealed an order to decrease the resident's fluid restriction to 1000 cubic centimeters (cc). Further review of physician's diet orders revealed a diet order to decrease the resident's fluids was not communicated to the Dietary Department until August 4, 2010 (24 days after the physician's order was written). According to the August 4, 2010 diet order, resident #2 was to receive 150 cc	F 281	Resident #8 is receiving a health shake with the noon meal. Resident #8's MAR reflects that three ounces of TwoCal is to be given three times per day. Resident #3's physician's orders and MARs is updated to read Lisinopril 2.5mg. Resident #3 is being asked to rinse their mouth after Advair administration. Resident #21's G-tube is being verified for proper placement in the gastro-intestinal prior to any administration of medication or feedings. Resident # 13 is receiving Nystatin cream under her breast as ordered. Resident #16 is receiving Tramasone cream to scratched areas as ordered. Resident #3's Kenolog treatment has been discontinued due to the rash being resolved. 2. Dietary reviewed the charts of all residents on fluid restrictions to insure that	

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F 281	Continued From page 8 of fluid twice daily with medication, 160 cc of milk, and 160 cc of orange juice at breakfast, 90 cc of milk and 90 cc of orange juice with lunch, 80 cc of milk with the evening meal, and 80 cc of orange juice with the nighttime snack. A review of resident #2's tray card with the August 25, 2010 noon meal revealed the resident was on a 1500-cc fluid restriction, not 1000 cc as ordered by the physician. Observation of resident #2 on August 24, 2010, at 5:15 p.m., and on August 25, 2010, at 12:40 p.m., revealed the resident received 240 cc of milk and 120 cc of orange juice based on the resident's previous fluid restriction of 1500 cc per day. An interview with the Dietary Manager on August 26, 2010, at 12:00 p.m., revealed the Dietary Department did not receive an order to decrease resident #2's fluid restriction to 1000 cc and the Dietary Department had continued to send fluids with resident #2's meals based on a 1500-cc fluid restriction. 2. Observation of resident #8 on August 24, 2010, at 12:05 p.m., revealed the resident was served the noon meal and the meal consisted of meat, mixed vegetables, macaroni and cheese, cornbread, chocolate cake, coffee, milk, and two juices. Further observation on August 26, 2010, at 12:05 p.m., revealed the resident received coffee, milk, and juice with the meal. A review of resident #8's tray card for the noon meal revealed the resident was on a regular diet and coffee, Kool-Aid, and whole milk were to be provided.	F 281	the tray cards reflect the current physician orders. A list was obtained from the pharmacy for all residents with orders for Lisinopril and Advair for comparison to the MARs and for Health Shakes and TwoCal for comparison to the tray cards to insure proper administration. Staff are verifying G-tube placement by inserting a small amount of air into the tube while listening to the stomach for gurgling sounds, and by aspirating stomach contents with a syringe and allowing the stomach contents to go back into the stomach prior to the administration of medications for all residents with G-tubes. The TARs have been reviewed to identify residents receiving treatments. Skin treatments are being applied as prescribed for all residents with orders in a timely manner. 3. Licensed nurses were re-educated by DNS/Staff Development Coordinator/designee prior to 9/30/10 on obtaining correct physician orders to include dosage, diagnosis, and special instructions. Education also included review of MARs/TARs during month end change over to ensure orders are carried over from month to month and include any special instructions, correct drug and dosage, following physician orders related	

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F 281	Continued From page 9 A review of resident #8's August 2010 physician's orders revealed an order for a health shake to be provided every day with the noon meal. An interview with the Dietary Manager on August 26, 2010, at 12:05 p.m., revealed the Dietary Manager did not think resident #8 was supposed to receive a health shake and if a health shake was not listed on the resident's tray card dietary staff would not provide one. An interview with the dietitian on August 26, 2010, at 2:50 p.m., revealed the facility implemented a new diet system on August 1, 2010, and resident 8's health shake did not get added into the new system. According to the dietitian, resident #8 did not receive a health shake with the lunch meal after August 1, 2010. 3. A review of resident #8's medical record revealed a nutritional assessment dated March 18, 2010. According to the assessment, the resident had sustained a weight gain and the dietitian recommended a supplement of TwoCal be decreased to three ounces three times a day. A physician's order was written for the TwoCal supplement on April 6, 2010. A review of resident #8's April 2010 Medication Administration Record (MAR) revealed nursing staff changed the TwoCal order on the MAR to reflect TwoCal, three ounces, three times a day. However, a review of resident #9's May, June, July, and August 2010 MARs revealed TwoCal was not administered from May 1, 2010 thru August 12, 2010. A review of the physician's orders dated August 13, 2010, revealed a "clarification order" was	F 281	to RD recommendations and notification to the dietary department. The Dietary Manager will attend the morning clinical meetings and will ensure that any new orders regarding RD recommendations or physician orders are noted and carried forth to the dietary cards. Licensed staff were re-educated on the procedure for inhaler administration and verification of G-tube placement. 4. Medical Records will compare the physician orders to the MARs and TARs at least five days a week for accurate transcription. Medical Records will audit the MARs and TARs weekly for documentation of administration and compliance with treatments. Any concerns will be reported to the DNS or designee and immediate action will be taken to correct. Results of this audit will be reported to the QA committee monthly by Medical Records for three months. The QA committee will discuss the need for further education, root cause, interventions, action plans, and further follow-up as indicated. The Staff Development Coordinator/Unit Managers will audit two Licensed Staff or KMA each week for correct administration G-tube medications and/or inhalers for Any concerns will be addressed immediately. Results of this audit will be reported to the QA committee monthly by the Staff Development Coordinator for	

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F 281	Continued From page 10 written for TwoCal to be administered to resident #8 three times a day. An interview with the Registered Dietitian (RD) on August 26, 2010, at 3:00 p.m., revealed the RD noticed when the RD reviewed the resident's record on August 10, 2010, that the supplement was not on the MAR to be administered to the resident, so the RD recommended the order be clarified. 4. Observation of the medication administration pass on August 25, 2010, at 10:20 a.m., revealed the nurse administered Lisinopril 2.5 mg to resident #3. A review of resident #3's August 2010 physician's orders revealed an order for one tablet of Lisinopril to be administered by mouth once daily. The physician's orders did not have the dosage of Lisinopril that was required to be administered to the resident. A review of resident #3's MAR revealed Lisinopril was also listed on the MAR without a dosage. On August 25, 2010, at 10:50 a.m., an interview conducted with the nurse who administered resident #3's medications revealed the medication label on the resident's box of Lisinopril had the dosage as 2.5 mg. The nurse stated he/she did not notice the MAR did not list the dosage for resident #3's Lisinopril. An interview with the Unit Manager on August 25, 2010, at 11:00 a.m., revealed physician's orders and MARs come pre-printed from the facility's pharmacy every month, and facility nurses were responsible for checking the physician's orders	F 281	three months. The QA committee will discuss the need for further education, root cause, interventions, action plans, and further follow-up as indicated. Medical Records and Nursing will audit the MARs and TARs at the beginning of each month to ensure all orders have been carried over correctly or new orders transcribed correctly. Concerns will be addressed immediately. Results of the audits will be reviewed during the monthly QA with an analysis and interventions. 5. Date of completion: 10-10-2010	

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F 281	Continued From page 11 and MARs to ensure they were accurate. In addition, the Unit Manager stated the nurses should check orders and MARs when new medications are delivered from the pharmacy to ensure the label on the medication matches the MAR. 5. Observation of the medication administration pass on August 25, 2010, at 10:20 a.m., revealed the nurse administered an Advair inhaler to resident #3. There was no observation that resident #3 rinsed his/her mouth after using the Advair inhaler. A review of resident #3's August 2010 physician's orders revealed an order for one puff of Advair to be administered to the resident twice daily. The order stated the resident should "rinse mouth after each use." A review of resident #3's August 2010 MAR revealed the MAR also stated the resident should rinse his/her mouth after using Advair. On August 25, 2010, at 3:30 p.m., an interview conducted with the nurse who administered resident #3's medications revealed the nurse was aware that the resident should rinse his/her mouth after using an Advair inhaler; however, the nurse forgot to ask resident #3 to rinse his/her mouth. 6. Observation of the medication administration pass on August 24, 2010, at 5:25 p.m., revealed the nurse administered Coumadin medication to resident #21 via the resident's gastric tube without checking to ensure the gastric tube was appropriately placed in the resident's gastro-intestinal tract.	F 281		

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F 281	Continued From page 12 A review of the facility's policy titled "Medication Administration Enteral Tubes" dated October 2007 revealed staff was required to verify tube placement by inserting a small amount of air into the tube and listening to the stomach for gurgling sounds, and by aspirating stomach contents with a syringe and allowing the stomach contents to go back into the stomach prior to the administration of medications via the gastric tube. 7. Observation on August 25, 2010, at 4:50 p.m., of resident #13 revealed the resident was sitting in a chair in the resident's room with blood on the front of the resident's shirt. Resident #13 stated his/her right breast was "hurting so bad" the resident was "getting nauseated." Resident #13 stated no treatment had been administered to the area. Observation of the skin underneath resident #13's right breast revealed a raw, red rash and the area was actively bleeding. A review of resident #13's preprinted physician's orders for June 2010 revealed an order for Calazime cream to be applied to the red areas under the resident's breast every day. Review of resident #13's Treatment Assessment Records (TARs) revealed the Calazime cream was applied eight days during the month of June 2010. There was no documentation this order was discontinued or changed. On August 21, 2010, a physician's order was obtained to wash under the resident's breast with warm soapy water, rinse, and then dry the area completely and apply Nystatin cream to the irritated tissue twice a day until the area healed. Review of resident #13's TARs revealed staff only provided the treatment four of nine times in the previous five days.	F 281		

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F 281	Continued From page 13 8. Observation of resident #16's skin on August 26, 2010, at 6:30 p.m., revealed a red/purple, slightly raised rash on the resident's lower back and buttocks/peri-area. The resident attempted to scratch at the area and stated that it "itched real bad" during the observation. A review of resident #16's preprinted physician's orders for June and July 2010 revealed an order for Calmoseptine ointment to be applied topically to the peri-area two times a day and as needed. There was also a physician's order for moisture barrier cream to be applied to the lower back and legs two times a day and as needed. A review of resident #16's TAR revealed the Calmoseptine cream was not applied during the month of June 2010 and July 2010, as ordered. Further review of the TAR revealed the moisture barrier was only applied 39 of the 122 times the barrier was ordered to be applied in June and July 2010. Further review of the August 2010 preprinted physician's orders for resident #16 revealed staff was to apply Tranasone cream to scratched areas every six hours. However, a review of the TAR for August 2010 revealed of the 100 times the cream was ordered to be applied it was only applied 36 times. Interview on August 26, 2010, at 6:10 p.m., with the Unit Manager revealed resident #16's rash would appear and go away from time to time. Interview further revealed the nurse providing care should have checked the TAR and provided the care accordingly. 9. Observation of the medication administration	F 281		

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F 281	Continued From page 14 pass on August 25, 2010, at 10:20 a.m., revealed the nurse administered oral medications, an inhaled medication, and a transdermal medication to resident #3. A review of a fax dated August 16, 2010, revealed a fax was sent to resident #3's physician related to a rash on the resident's inner thigh and around the resident's waistline. According to the fax, the rash was "very itchy." A review of resident #3's physician's orders dated August 16, 2010, revealed Kenalog medication was ordered to be applied to the rash on the resident's inner thigh and around the resident's waist twice daily until the resident's skin was "clear." A review of resident #3's August 2010 treatment record (TAR) revealed the first dose of Kenalog was not applied until August 18, 2010, two days after the medication was ordered. In addition, according to the TAR, from August 16-25, 2010, resident #3 missed five doses of the medication. Four of the doses were missed at 7:00 p.m. An interview with the nurse who administered resident #3's medications on August 25, 2010, revealed the nurse was not sure why the medication was not administered until August 18, 2010. The nurse stated the procedure for ordering and obtaining new medications was to fax a copy of the order to the facility's pharmacy. According to the nurse, if the fax was sent before 5:00 p.m., the medication was delivered the same day. The nurse stated the pharmacy did not deliver medications on Sunday; however, August 16, 2010, was on Monday. The nurse continued that the day shift nurse was responsible for	F 281		

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F 281	Continued From page 15 providing all resident treatments for the day shift. The nurse stated the medication aide (KMA) could also help with treatments when the KMA came in to work at 3:00 p.m. On August 25, 2010, from 10:10 p.m. to 10:55 p.m., an interview with three nurses who worked the 7 p.m. to 7 a.m. shift and a KMA who worked the 3 p.m. to 11 p.m. shift revealed the nurses believed the KMA was required to complete resident treatments that were scheduled for 7:00 p.m., and the KMA believed the nurse was required to complete these treatments. An interview with the DON on August 26, 2010, at 3:20 p.m., revealed the facility had changed staffing the week prior (August 15-16, 2010) and added another nurse on the day shift to complete treatments; however, the KMA was responsible to complete treatments during their shift. The DON stated he/she was aware staff had not completed some residents' treatment records, however, did not know the reason/cause as to why the treatments had not been provided.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the services provided by the facility were in accordance with the plan of care for one (1) of twenty (20)	F 282		

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F 282	Continued From page 16 residents. According to resident #8's care plan the resident required the use of a tab alarm. However, observation of resident #8 revealed the resident was not wearing a tab alarm. The findings include: A review of resident #8's medical record revealed the resident was admitted on March 1, 2008, with diagnoses that included Alzheimer's Disease and Anxiety. A review of the resident's most recent assessment, a significant change assessment dated July 22, 2010, revealed the resident had fallen in the last 30 days. According to the Resident Assessment Protocols (RAPs) dated July 22, 2010, the resident's falls had increased as a result of a decline in the resident's activities of daily living (ADL) and painful edema to the right lower extremity. The RAP stated, "proceed to care plan for fall prevention." A review of resident #8's care plan dated July 22, 2010, revealed a tab alarm was initiated on July 10, 2010, to prevent falls. However, observations of resident #8 on August 24, 2010, at 11:50 a.m., 12:05 p.m., 12:20 p.m., 3:05 p.m., 4:00 p.m., 4:45 p.m., and 5:02 p.m., on August 25, 2010, at 10:15 a.m., 11:30 a.m., 2:50 p.m., and 5:05 p.m., and on August 26, 2010, at 12:00 p.m., revealed resident #8 was not wearing a tab alarm. A review of resident #8's SRNA Kardex revealed a tab alarm was not listed as a care need for this resident. An interview with the Unit Manager on August 26, 2010, at 5:15 p.m., revealed resident #8 took off the tab alarm because the resident's condition improved and the resident was independent with	F 282	F282 1. Resident #8 has been reassessed for use of the tab alarm. The tab alarm has been discontinued at this time. The Care Plan has been updated. 2. All residents have been reviewed by the interdisciplinary team (IDT) for appropriate use of tab alarms. Results were relayed to the resident/responsible party. Care Plans and the SRNA Kardex were reviewed and updated to reflect any changes. 3. Licensed staff were educated by DON/SDC/Designee prior to 9/30/10 to update the Care Plans and SRNA Kardex with any interventions and to discontinue from the Care Plans/SRNA Kardex any intervention that was assessed to be no longer necessary by the physician or IDT. 4. The Unit Manager/Nursing Administration/Medical Records will audit weekly the use of alarms as it relates to nursing intervention, orders to care plan and SRNA Kardex to actual usage. Concerns will be addressed immediately. Results of the audit will be reported to the QA committee for three months. The QA committee will discuss the need for further education, root cause, interventions, action plans, and further follow-up as indicated. 5. Date of completion: 10-10-2010	10/10/10

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F 282	Continued From page 17 ambulation. The Unit Manager stated the tab alarm should have been discontinued from the resident's care plan because the resident no longer needed the tab alarm. According to the Unit Manager, staff took resident care plans to the morning meetings at the facility and updated care plans with any new physician's orders or changes. The Unit Manager stated nurses should also update care plans and the SRNA Kardex (CNA care plans) when new orders were received or with changes in the resident's condition.	F 282	F309 1. Resident #5 was reassessed and the physician/responsible party were notified on 8-26-2010 regarding the skin redness and excoriated area under the left breast. Appropriate treatment orders were obtained as needed. Care Plans were updated to reflect any changes.	10/10/10
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of the facility's skin management policy, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being for four (4) of twenty (20) sampled residents. Residents #5, #7, #13, and #16 developed redness/excoriation to the skin. The facility failed to ensure treatment was provided to the residents' skin. The findings include: A review of the facility's Skin Management and	F 309	Resident #13 was reassessed and the physician/responsible party were notified on 8-25-2010 regarding the rash under the right breast. Appropriate treatment orders were obtained as needed. Care Plans were updated to reflect any changes. Resident #16 was reassessed on 8-28-2010 regarding the rash. Treatments will continue as ordered. Tramasone cream has been changed to daily. Care Plans were updated to reflect any changes. Resident #7 was reassessed and the physician/responsible party were notified on 8-24-2010 regarding the reddened areas on the buttocks, scrotum, and inner thighs. Appropriate treatment orders were obtained as needed. Care Plans were updated to reflect any changes. 2. A skin sweep on 9-15-2010 was completed on all residents. Treatments were obtained for any areas that were identified.	

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F 309	Continued From page 18 Prevention Policy that was not dated revealed the charge nurse was required to complete weekly skin rounds and complete a "Weekly Skin Rounds Form." According to the policy, any new skin condition would be documented on the appropriate form (Individual Skin Report and the Skin Ulcer Change of Condition Evaluation, if appropriate). In addition, Certified Nursing Assistants (CNAs) were required to complete a total body skin observation at a minimum of every shower/bath day. If a new skin issue was identified, the CNA was required to notify the charge nurse and a copy of the form was to be given to the ADON/designee. According to the Skin Management Policy, if a new skin condition was identified the charge nurse was required to notify the resident's physician and the resident's family. In addition, according to the policy, all residents with wounds and other skin concerns would be reviewed during the weekly At-Risk Meeting. 1. An observation conducted on August 25, 2010, at 2:50 p.m., revealed resident #5 had a red, excoriated rash under both breasts. The observation revealed broken skin under the left breast that was approximately one inch long with no bleeding/drainage noted. A caked-on white substance was also observed under each breast. An interview conducted on August 25, 2010, at 2:50 p.m. and 3:20 p.m., with the Licensed Practical Nurse (LPN #1) who cared for resident #5 revealed the LPN was unaware of the rash and the broken skin under resident #5's breast. The LPN stated when any new skin issues were noted or anything out of the ordinary was observed a skin report was required to be completed. LPN #1 confirmed there were no skin	F 309	3. Licensed staff were re-educated by DON/SDC/Designee prior to 9/30/10 on the skin policy which includes use of the C.N.A. Skin Care Alert sheet not only during showers but daily during routine care and the weekly skin assessments completed by the licensed nurses. Nursing Administration will review the C.N.A Skin Care Alert sheet, weekly skin assessments, 24 hour report, and physician orders during the clinical meetings to ensure any areas of concern are addressed. 4. Medical Records will audit the physician orders for completeness and will compare to the MARs/TARs for accurate transcription at least five days per week. In addition to the weekly skin assessments conducted by the licensed staff, the treatment nurse will audit the skin of eight residents per week to monitor for accuracy. This information will also be presented to the QA meeting monthly by Medical Records for three months. The QA committee will discuss the need for further education, root cause, interventions, action plans, and further follow-up as indicated. 5. Date of completion: 10-10-2010	

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F 309	Continued From page 19 reports addressing the redness under resident #5's breasts, or the broken skin under the resident's left breast. The interview revealed that if the State Registered Nurse Aide (SRNA) identified a rash or skin breakdown, the SRNA was required to document the rash or skin breakdown on the SRNA bath log sheet. An interview conducted on August 25, 2010, at 3:35 p.m., with the Unit Coordinator revealed when performing a skin assessment the nurse was required to document anything found on the skin that was not normal, such as skin tear, mole, bruise, open areas, or excoriation. The Unit Coordinator confirmed there was no skin incident report completed addressing resident #5's rash or broken skin found under the resident's breast. An interview conducted on August 25, 2010, at 3:10 p.m., with the Director of Nursing (DON) revealed any skin issue that was a new problem for the resident was required to be documented on the skin assessment sheet. An interview conducted on August 25, 2010, at 4:30 p.m., with LPN #2 revealed any change in a resident's skin would be documented in the medical record. The LPN reported a change of condition packet would have been completed for any new skin issues found on a resident. A review of resident #5's physician's orders for May 2010 revealed an order for Nursing to apply Calazime cream to the red areas under the resident's breast, then to place 4 by 4's over the area, and to monitor for further skin breakdown. Review of the Treatment Administration Record (TAR) for May 2010 revealed the Calazime cream was to be applied at 7:00 a.m. and 7:00 p.m. The	F 309		

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F 309	Continued From page 20 TAR revealed the cream was only applied 20 of the 48 times the cream was scheduled to be applied during the month of May 2010. Record review of resident #5's care plan dated May 18, 2010, revealed staff was to apply Calazime cream under the resident's breast. The care plan revealed under the problem area dated May 27, 2010, that staff noted a rash under the resident's breast. A review of the SRNA Skin Alert forms for July and August 2010 for resident #5 revealed redness was identified under the resident's breast on July 9, 10, 14, and 27, 2010; however, nothing was documented for August 2010. The review revealed on July 27, 2010, the nurse was notified of the redness under the resident's breast and a protectant cream was applied. Review of resident #5's weekly skin assessment performed/documented by nursing staff revealed on August 4, 2010, redness was identified under the resident's right breast; however, the skin was intact. The review revealed on August 18, 2010, a red area was identified below the resident's breast. However, the physician was not notified and no treatment was initiated. 2. Observation on August 25, 2010, at 4:50 p.m., of resident #13 revealed the resident was sitting in a chair in the resident's room with blood on the front of the resident's shirt. Resident #13 complained of the right breast "hurting so bad" the resident was "getting nauseated." Resident #13 stated no treatment had been administered to the area. Observation revealed the skin under the resident's right breast had a raw, red rash and the area was actively bleeding.	F 309		

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F 309	Continued From page 21 A review of resident #13's preprinted physician's orders for June 2010 revealed staff was to apply Calazime cream to the red areas under the resident's breast every day. However, a review of resident #13's TARs revealed the Calazime cream was only applied eight days during the month of June 2010. There was no documentation this order was discontinued or changed. On August 21, 2010, a physician's order was obtained to wash under the resident's breast with warm soapy water, rinse, and then dry the area completely, and apply Nystatin cream to the irritated tissue twice a day until the area healed. Review of resident #13's TARs revealed staff only cleansed and applied the cream four of the nine times the cream was scheduled to be applied during the previous five days. Review of resident #13's Weekly Skin Rounds revealed redness was noted under the resident's breast on July 24, 2010; however, the physician was not notified until August 21, 2010. There was no documentation that the resident's physician was notified when the redness changed and the area started having bloody drainage. An interview conducted on August 25, 2010, at 5:05 p.m., with LPN #1 who was responsible for providing care to the resident revealed the LPN was unaware of the bloody area under resident #13's right breast. 3. Observation of resident #16's skin on August 26, 2010, at 6:30 p.m., revealed a red/purple, slightly raised rash on the resident's lower back and buttocks/peri-area. The resident attempted to scratch at the area and stated that it "itched real bad" during the observation.	F 309		

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ROCKCASTLE HEALTH & REHABILITATION CENTER	371 WEST MAIN STREET BRODHEAD, KY 40409

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 22 Prior to the observation, an interview conducted on August 26, 2010, at 4:45 p.m., with LPN #2 revealed no treatment was being provided for resident #16 on August 26, 2010, due to the fact that the rash and scratches were no longer visible. LPN #2 further stated that the physician would be called and the order to treat the rash/scratches would be discontinued. A review of resident #16's preprinted physician's orders for June and July 2010 revealed an order for Calmoseptine ointment to be applied topically to the peri-area two times a day and as needed. There was also a physician's order for moisture barrier cream to be applied to the resident's lower back and legs two times a day and as needed. A review of resident #16's Treatment Assessment Record (TAR) revealed the Calmoseptine cream was not applied during the month of June 2010 and July 2010 as ordered. Further review of the TAR revealed the moisture barrier was only applied 39 of the 122 times the barrier was ordered to be applied in June and July 2010. Further review of the August 2010 preprinted physician's orders for resident #16 revealed staff was to apply Tranasone cream to scratched areas every six hours. However, a review of the TAR for August 2010 revealed of the 100 times the cream was ordered to be applied the cream was only applied 36 times. A review of physician's progress notes dated August 16, 2010, revealed the physician documented "a little bit of skin excoriation" and resident #16 was scratching the area. The physician further documented the resident had	F 309		

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F 309	Continued From page 23 medications for pruritus (itching). However, review of the TARs for June and July 2010 revealed resident #16 was not receiving the medications for pruritus as ordered. Interview on August 26, 2010, at 4:30 p.m., with LPN #3 revealed the LPN was unaware of any treatment resident #16 was receiving for the rash on the resident's body. Further interview on August 26, 2010, at 6:30 p.m., during the skin assessment with LPN #3, revealed the LPN was unaware of the rash on resident #16. LPN #3 stated he/she had only known the resident to have scratches on the resident's back. Interview on August 26, 2010, at 6:10 p.m., with the Unit Manager revealed resident #16's rash would appear and go away from time to time. Interview further revealed the nurse providing care should have checked the TAR and provided the care accordingly. 4. Observation of resident #7 on August 24, 2010, at 10:50 a.m., during the initial tour of the facility revealed staff was present assisting the resident with a bed bath. Observation of the resident's buttocks, scrotum, and inner thighs revealed the areas were bright red. The redness to the scrotum and inner thighs did not blanch. The staff was observed to apply "Nutrashield" cream to the reddened areas. Further observation of resident #7's skin on August 24, 2010, at 5:25 p.m., with the staff nurse assigned to provide treatments/conduct skin assessments on the unit where resident #7 resided revealed the resident's bottom, scrotum, and inner thighs continued to be bright red. According to the nurse, the resident's left inner	F 309		

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F 309	Continued From page 24 thigh appeared to have a "blister there at one time." According to the nurse, resident #7 had a treatment ordered for the area but the nurse was unsure how long the reddened areas had been present. An interview with the nurse aide assigned to resident #7 on August 24, 2010, at 5:45 p.m., revealed the resident's skin was not reddened approximately two weeks prior; however, the resident did get red at times and it "really, really hurts." The nurse aide stated when the resident's skin got red, the nurse aide left the resident's brief open so the resident's skin could get air. Interviews on August 25, 2010, at 5:05 p.m. and 11:00 p.m., with two other nurse aides (CNAs #1 and #2) who provided care for resident #7 revealed they were aware resident #7 had redness to the bottom and scrotal area. CNA #1 stated resident #7 stated the areas to the scrotum and legs "hurt." CNA #1 stated he/she applied a protective barrier to the areas. CNA #2 stated resident #7's redness/rash began to look better at times but never completely went away. The CNA stated he/she always notified the nurse of the redness/rash and the nurse would ask how long the cream (protective cream) had been in use and would tell the CNAs to continue to put on the cream or leave the areas open to air. An interview with the nurse assigned to provide care to resident #7 on August 24, 2010, at 6:00 p.m., revealed the nurse was not aware the resident's skin was reddened prior to being told a few minutes before the interview. The nurse stated the resident had a rash that "comes and goes" and had orders for Nystatin cream to apply to the rash.	F 309		

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F 309	Continued From page 25 An interview with the KMA for resident #7 on August 25, 2010, at 3:30 p.m., revealed the KMA was not aware the resident had reddened areas. A review of "CNA Skin Care Alert" revealed resident #7's groin area was red/rash/irritated on July 6, 16, and 20, 2010, and on August 3, 13, and 17, 2010. According to the CNA Skin Care Alert form, the CNA must complete the form for all residents on shower days and any time a change was noted/observed to the resident's skin. The form stated the caregiver must then give the form to the nurse immediately. However, a review of the forms revealed the nurse had only signed three of the six forms that stated resident #7's groin area was red. In addition, a review of "Weekly Skin Rounds" completed by facility nurses on July 6, August 3, and August 17, 2010, the same days redness was documented on the alert forms, revealed the nurses did not assess the reddened areas. A review of the weekly skin rounds forms revealed on July 13, 2010, resident #7's buttocks were "red blanchable." A review of resident #7's medical record revealed no evidence resident #7's physician was notified that resident #7 had redness/irritation to the resident's bottom, inner thighs, or groin area. A review of the facility's Skin Management and Prevention Policy/Procedure that was not dated revealed if a new skin condition was identified the charge nurse was required to notify the resident's physician and the resident's family. An interview with resident #7's Responsible Party (RP) on August 26, 2010, at 2:48 p.m., revealed the RP was not aware the resident had	F 309		

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F 309	Continued From page 26 reddened/excoriated skin areas. An interview with the DON on August 26, 2010, at 3:20 p.m., revealed the facility had changed staffing the week prior (August 15-16, 2010) and another nurse had been added on the day shift to complete treatments; however, the KMA was responsible to complete treatments during their shift. The DON stated he/she was aware staff had not completed some residents' treatment records; however, the DON did not know the reason/why the treatment records had not been completed. An interview with the Unit Manager on August 26, 2010, at 5:15 p.m., revealed when a skin issue was identified staff should complete an Altered Skin Integrity form and an Individual Skin Report form. The Unit Manager received the forms after they were completed and monitored to ensure the skin conditions had been assessed, were being treated, and were improving. However, according to the Unit Manager, most of the facility staff was new and may not have known to complete the required forms. The Unit Manager stated the facility also monitored the Weekly Skin Rounds forms in the At-Risk Meeting. However, according to the Unit Manager, the staff at the meeting may have just been looking at the form to ensure the weekly skin assessments had been completed and was not monitoring to ensure all skin conditions had been addressed.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323		

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F 323	Continued From page 27 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible. The facility's hot water temperature in three (3) of the resident rooms and one (1) shower room was observed to range from one hundred twelve (112) to one hundred eighteen (118) degrees Fahrenheit. The findings include: Observations of hot water temperatures conducted on August 26, 2010, at 3:55 p.m., revealed the water temperatures for resident rooms 159, 165, and 167, and the resident shower room on the West Hall ranged from 112 to 118 degrees Fahrenheit. An interview conducted on August 26, 2010, at 3:50 p.m., with the Maintenance Supervisor (MS) revealed resident room water temperatures were randomly monitored weekly and recorded in a log book. The MS added the water temperatures in resident rooms on the West Hall were usually higher than 110 degrees Fahrenheit, but after the water ran for a while, the temperature cooled down. An interview conducted on August 26, 2010, at 4:15 p.m., with West Wing Licensed Practical Nurse revealed no reported resident injuries from hot water.	F 323	F323 1. No specific resident was found to be affected by this deficient practice. 2. All residents on the West unit had the potential to be affected by the water exceeding the temperature range. 3. The hot water line was re-routed by the maintenance department on 9-06-2010. 4. The maintenance department will be checking and logging the water temperatures in a minimum of three rooms per unit at least five days per week. Any concerns will be addressed immediately. The administrator will audit the logs weekly and report findings to the monthly QA committee for three months. The QA committee will discuss the need for further education, root cause, interventions, action plans, and further follow-up as indicated. 5. Date of completion: 10-10-2010	10/10/10

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F 323	Continued From page 28 Record review of the Weekly Resident Room Temperature Logs dated January 7, 2010 through August 25, 2010, revealed resident room water temperatures ranged from 102 to 110 degrees Fahrenheit.	F 323	F328 1. Resident #7 toenails were trimmed on 9-2-2010 during a Podiatrist appointment. 2. All resident's toenails have been assessed by nursing service.	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one (1) of twenty (20) residents received proper foot care. Resident #7's toenails were observed to be long and thick, curving down toward the resident's toes. There was no evidence proper treatment and care had been provided for the resident's feet. The findings include: Observation of resident #7 on August 24, 2010, at 10:50 a.m., during the initial tour of the facility revealed staff was present assisting the resident with a bed bath. Observation of the resident's	F 328	3. The nursing staff were educated by DON/SDC/Designee prior to 9/30/10 regarding checking nails of residents during daily care. Nail care that cannot be provided by nursing staff will be placed on a the Podiatrist list. A staff member will assist the Podiatrist as needed and will ensure that residents on the list are seen. 4. The DNS will audit the Podiatry list to the actual visit of the Podiatrist to assess if residents were seen timely. Results of the audit will be reported to the monthly QA committee for three months. The QA committee will discuss the need for further education, root cause, interventions, action plans, and further follow-up as indicated. 5. Date of completion: 10-10-2010	10/10/10

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F 328	Continued From page 29 toenails revealed the nails were thick and long and were curving downward toward the resident's toes. An interview with the resident during this observation revealed a "specialist has to cut them...not been here for a long time." A review of resident #7's medical record revealed the resident was admitted to the facility on January 22, 2010, and had diagnoses that included diabetes. A review of the admission nursing assessment revealed the portion of the assessment to assess the resident's feet was not completed. A review of the resident's June, July, and August 2010 physician's orders revealed the resident could see the podiatrist of the resident's choice. Interviews with two nursing assistants on August 25, 2010, at 3:15 p.m. and 4:45 p.m., revealed nursing assistants provided nail care during showers and documented that nail care was provided on the CNA Skin Care Alert form; however, nursing assistants did not provide toenail care for diabetic residents. It was the nurse's responsibility to provide toenail care for residents with diabetes, according to the nursing assistants. According to one of the nursing assistants, resident #7's toenails had been thick and long since admission. The nursing assistant stated he/she was informed the podiatrist would have to treat the resident's toenails. Interviews with two nurses on August 25, 2010, at 2:50 p.m. and 3:30 p.m., revealed nursing assistants should alert nurses when diabetic residents require nail care. The nurses stated if a resident had a foot concern/issue that Nursing felt uncomfortable providing care for, Nursing put the resident on a list for the podiatrist to see the	F 328		

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F 328	Continued From page 30 resident. The nurse who was providing care for resident #7 on August 25, 2010, stated he/she went to put the resident's name on the list for podiatry to see; however, the resident's name was already on the list. According to the nurse, the podiatrist was in the facility on the previous Thursday; however, the nurse was not sure if the resident's name was on the list prior to Thursday. A review of the podiatry list revealed the list was kept in a book at the nurses' station. Resident #7's name was on the list with "per family request" written beside the resident's name. An interview with the Unit Manager on August 25, 2010, at 11:20 a.m., revealed nurses could put a resident's name on the list to be seen by the podiatrist if the nurse felt it was necessary. The Unit Manager stated the podiatrist came every three months and was at the facility the previous week. The Unit Manager was unable to provide evidence the resident's toenails had been addressed/treated during the resident's stay at the facility.	F 328		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371		

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F 371	Continued From page 31 by: Based on observation, interview, and record review, it was determined the facility failed to store, prepare, distribute, and serve food under sanitary conditions. Observation of the kitchen and tray line on August 24, 2010, revealed a vent in the ceiling above the serving line contained condensation which was dripping onto the serving line. Multiple flies were observed in the kitchen. The floor in the food preparation room was dirty and sticky and staff was observed to prepare a sandwich for a resident without wearing gloves. The findings include: 1. Observation of the kitchen on August 24, 2010, at 10:45 a.m., revealed the floor in the food preparation room was dirty and sticky. An interview with the Dietary Manager (DM) on August 24, 2010, at 4:00 p.m., revealed the food preparation room floor was sticky because it needed to be waxed. The DM further stated he/she had not reported the need for the floors to be waxed to anyone. 2. Observation of the serving line for the noon meal on August 24, 2010, at 12:22 p.m., and the evening meal on August 24, 2010, at 4:35 p.m., revealed a vent above the serving line had condensation that was dripping onto the trays/food on the serving line. An interview held with the DM on August 24, 2010, at 4:15 p.m., revealed the Maintenance Department was aware of the problem, but was uncertain how to fix the problem. The DM further stated the dripping condensation had been an ongoing problem during the summer months.	F 371	F371 1. No specific resident was found to be affected by this deficient practice. 2. All residents have the potential to be affected by the condensation dripping from the vent above the serving line, flies, and preparing food while not wearing gloves. 3. The floor in dietary will be cleaned and waxed on 9-23-2010 by housekeeping. The vent above the tray line was disconnected and rerouted on 8-27-2010. The dietary department was educated by the Administrator on the notification process of equipment or maintenance issues. An air curtain was ordered on 9-22-2010 for the dietary stockroom. Chemical free flying insect control lights have been installed in the stockroom and in the hallways of the facility. A new pest control company has been contracted as of 8-30-2010. The dietary department was educated on the use of gloves for food preparation by the dietary manager on 8-27-10. 4. The Administrator will audit the kitchen weekly for the next four weeks related to proper functioning of equipment, condition of floors, as well as use of gloves during food preparation. Results of the audit will be reported by the	10/10/10

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F 371	Continued From page 32 An interview with the Maintenance Manager on August 26, 2010, at 4:55 p.m., revealed the Maintenance Manager was unaware the vent was dripping condensation in the Dietary Department above the serving line. The Maintenance Manager further stated if an employee found a maintenance problem a work order was required to be sent to the Maintenance Department so the problem could be resolved. The Maintenance Manager further stated that at no time had he/she received a work order to fix the vent in the Dietary Department. 3. Observation of the serving line and kitchen of the facility on August 24, 2010, at 4:40 p.m., during the evening meal, revealed flies in the serving line area, flies on the napkins and lids sitting on a cart beside the hand sink, flies on the food cart, and a fly on a dish of covered pudding. An interview with the DM on August 25, 2010, at 2:50 p.m., revealed the facility had a pest control contract but it did not address flies. The DM further stated in the past the facility utilized a fly trap light; however, the bulb in the fly trap was no longer working. The DM felt the problem with flies was due to the facility's dietary staff leaving the outside door open during breaks. 4. Observation of the serving line for the evening meal on August 24, 2010, at 5:20 p.m., revealed a dietary aide prepared a turkey sandwich for a resident with his/her bare hands. During an interview on August 24, 2010, at 5:25 p.m., the dietary aide stated, "I know what I did was wrong. I should have put gloves on to make the sandwich." The dietary aide stated he/she	F 371	Administrator monthly to the QA committee for three months. The QA committee will discuss the need for further education, root cause, interventions, action plans, and further follow-up as indicated. 5. Date of completion: 10-10-2010	

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F 371	Continued From page 33 had been taught by the facility to always wear gloves when preparing food. An interview with the DM on August 24, 2010, at 6:15 p.m., revealed the employee should have worn gloves when making the turkey sandwich for the resident. The DM stated the dietary employees were trained to always wear gloves when handling food and to never handle food with their bare hands.	F 371	F431 1. The insulin and box of Ipratorpium Bromide with Albuterol Sulfate and Xopenex was disposed of and reordered. Room temperatures are within the appropriate range. 2. All medication rooms were audited for opened and undated insulins. Any insulins found to be opened and undated were disposed of and reordered. Medications that required storage at specific temperatures were examined and if found to be stored at the improper temperature were removed. 3. Licensed staff and KMAs were educated by DON/SDC/Designee prior to 9/30/10 on dating medications when opened and monitoring of the medication room temperatures which includes notifying plant operations if the temperature is out of range. 4. Nursing Administration will review the medication rooms and carts weekly for undated medications. Plant operations will audit the medication room temperatures to ensure temperatures are not above 77 degrees. Results of the audits will be presented by the DNS and plant operations to the monthly QA committee for three months. The QA committee will discuss the need	10/10/10
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 34 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to store all drugs under proper temperature controls, and failed to label all drugs and biologicals used in the facility in accordance with currently accepted professional principles. The facility had one (1) vial of open (in use) insulin that did not have the date when the bottle was opened written on the bottle. In addition, the medication room contained Ipratropium Bromide with Albuterol Sulfate for a nebulizer treatment, Albuterol Sulfate for a nebulizer treatment, and Xopenex for a nebulizer treatment, which were stored at improper temperature levels. The findings include: Observation of the facility's medication room on the Indian Trail Wing of the facility on August 26, 2010, at 5:55 p.m., revealed a box of Ipratropium Bromide with Albuterol Sulfate and Xopenex for nebulizer treatments being stored on the counter. The manufacturer's labels for both drugs stated to store the medications at a temperature of 68-77 degrees Fahrenheit. A box of Albuterol Sulfate for nebulizer treatments was also being stored on the counter. The manufacturer's label stated to store the medication at a temperature of 36-77 degrees Fahrenheit. Observation on August 26,	F 431	for further education, root cause, interventions, action plans, and further follow-up as indicated. Date of completion: 10-10-2010	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185246	A. BUILDING _____ B. WING _____	C 08/26/2010

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F 431	Continued From page 35 2010, at 5:55 p.m., revealed the temperature of the medication room was 81.7 degrees Fahrenheit. Further observation revealed a bottle of Novolin R insulin was opened and available for use that did not contain a date to indicate when the bottle was opened. An interview with the Charge Nurse (CN) on the Indian Trail Unit of the facility on August 26, 2010, at 6:15 p.m., revealed temperatures were not routinely monitored in the medication room. The CN further revealed the Novolin R insulin should have been dated by the nurse who opened the bottle and should be discarded after being opened for 30 days. According to the CN, night shift nurses were required to check for outdated medications and should have discarded the insulin.	F 431		

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	185246	A. BUILDING 01 - MAIN BUILDING-01 B. WING	08/26/2010

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K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on August 26, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	K-051 1. No residents were found to have been negatively effected. 2. All residents had the potential to be effected. 3. On 8/31/10 FASCO (Fire Systems Company) re-programmed fire alarm so that lights would stay on during the silence mode. 4. Maintenance department will test fire alarm system weekly on silence mode to ensure lights stay on. Results will be kept in a log. The administrator will audit the log weekly and report findings to the monthly QA committee for three months. The QA committee will discuss the need for further education, root cause, interventions, action plans, and further follow-up as indicated. 5. Corrected by 9/30/2010	
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K 051		9/30/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
David Dickerson	NHA	9/23/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 051	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the fire alarm system according to NFPA standards. This deficient practice affected ten (10) of ten (10) smoke compartments, staff, and all the residents. The facility has the capacity for 109 beds with a census of 100 on the day of the survey. The findings include: During the Life Safety Code tour on August 26, 2010, at 11:45 a.m., with the Director of Maintenance, a test of the fire alarm system revealed after silencing the alarm the visual indicators were observed not to operate. The visual indicators must continue to operate until the system has been reset. An interview with the Director of Maintenance on August 26, 2010, at 11:45 a.m., revealed the Director Maintenance was not aware the fire alarm system was not operating correctly. Reference: NFPA 72 (1999 Edition). 1-5.7.1 Visible Zone Alarm Indication. If required, the location of an operated initiating device shall be visibly indicated by building, floor, fire zone, or other approved subdivision by annunciation, printout, or other approved means. The visible indication shall not be canceled by the operation of an audible alarm silencing means.	K 051		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147		

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K 147	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that electrical wiring and standards met NFPA requirements. This deficient practice affected one (1) of ten (10) smoke compartments, staff, and approximately twenty (20) residents. The facility has the capacity for 109 beds with a census of 100 on the day of the survey. The findings include: During the Life Safety Code tour on August 26, 2010, at 9:55 a.m., with the Director of Maintenance, two extension cords were observed to be plugged into a receptacle in the attic area of the East Wing. Flexible cords and cables cannot be used on a permanent basis in this area. An interview with the Director of Maintenance on August 26, 2010, at 9:55 a.m., revealed heat and air contractors connected one of the extension cords to a pump in the heat/air unit about a year ago. The Director of Maintenance did not know the purpose of the other extension cord. Reference: NFPA 70 (1999 Edition). 400-8. Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following: 1. As a substitute for the fixed wiring of a structure	K 147	K-147 1. No residents were found to have been negatively effected. 2. All residents had the potential to be effected. 3. Extension cords were removed and wiring was hard wired on 9/2/10. 4. Maintenance department visually inspected all accessible attic areas and found no more extension cords. Maintenance department will visually inspect attic areas after contract maintenance work to ensure proper wiring. 5. Corrected by 9/30/2010	9/30/10

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K 147	Continued From page 3 2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors 3. Where run through doorways, windows, or similar openings 4. Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code	K 147		